TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MCHS RED WING HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-0056-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for review with their request.

Amount in Dispute: $3,271.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual is unable to respond comprehensively to this dispute . . . Rule 133.307(c)(2)(N)(i-iii) specifically states the requestor for medical fee dispute resolution shall include . . . a position statement of the disputed issue(s) . . . The requestor's DWC60 contains nothing that addresses the requirements of (c)(2)(N)(i-iii)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2016	Outpatient Hospital Services	$3,271.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. Labor Code §413.031(a)(1) entitles health care providers to a review of services if payment is denied or reduced.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 370 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE134.403(G)
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Under what authority is this request for medical fee dispute resolution considered?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Has the requestor justified that the payment amount sought is a fair and reasonable rate of reimbursement?
4. Has the respondent justified that the payment made is a fair and reasonable rate of reimbursement?
5. Is additional reimbursement due?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Minnesota to an injured employee with an existing Texas Workers' Compensation claim. Labor Code §413.031(a)(1) entitles a health care provider to a review of a medical service provided if the health care provider is denied payment or paid a reduced amount for the medical service rendered. The health care provider was dissatisfied with the insurance carrier's reduction of payment on a medical bill. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical dispute resolution under Labor Code§413.031(a) in accordance with 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. This dispute regards outpatient hospital facility services rendered in Minnesota. The division's *Hospital Facility Fee Guideline—Outpatient*, as set forth in Title 28 Texas Administrative Code §134.403, is applicable only to acute care hospitals appropriately licensed by the Texas Department of State Health Services, as defined in Rule §134.403(b)(1). The requestor is not licensed by the Texas Department of State Health Services. No documentation was found to support a negotiated contract or that the services were provided through a workers' compensation health care network. As out-of-state outpatient hospital services are not covered by an established medical fee guideline, reimbursement is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f).
3. In the following analysis, the division examines the evidence presented to date in support of, or to refute, each party's determination of a fair and reasonable payment amount, in order to establish which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the disputed services. The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence. If the requestor meets the burden to show that the amount sought is a fair and reasonable reimbursement, the position of the respondent will then be reviewed to determine if the amount paid was a fair and reasonable reimbursement for the disputed services.

Title 28 Texas Administrative Code §134.1(f) requires that:

> Fair and reasonable reimbursement shall:
> (1) be consistent with the criteria of Labor Code §413.011;
> (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
> (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 656 (Texas 2004).

Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 104 (Texas Appeals – Austin 2003, petition for review denied), that "each . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

Texas Labor Code §413.011(d) requires that:

> Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

Title 28 Texas Administrative Code §133.307(c)(2)(N) requires that the requestor provide a position statement of the disputed issue(s) that shall include:

> (i) the requestor's reasoning for why the disputed fees should be paid or refunded,
> (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
> (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

The requestor did not include a position statement with the request for dispute resolution. The request will therefore be reviewed based on the information available at the time of review.

28 Texas Administrative Code §133.307(c)(2)(O), requires that the requestor provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation finds that no information was presented to support that the payment amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. The requestor has not explained or supported that the requested reimbursement would satisfy the requirements of 28 Texas Administrative Code §134.1. The division therefore concludes that the request for additional reimbursement is not supported.

After thorough review of the information submitted for consideration, the Division concludes that the requestor has not discussed, demonstrated or justified by a preponderance of the evidence that the payment amount sought is a fair and reasonable rate of reimbursement for the disputed services.

4. Because the requestor has failed to meet its burden to show that the amount it is seeking is a fair and reasonable rate of reimbursement, the respondent's position is not reviewed. However, the division notes that the respondent paid the requestor 200% of the applicable Medicare Outpatient Prospective Payment System reimbursement for the disputed services. While this methodology is not applicable to out-of-state outpatient hospital services, the amount paid is comparable to the amount a licensed Texas outpatient acute care hospital would be allowed under the division's *Hospital Facility Fee Guideline—Outpatient* for the same or similar services.
5. For the reasons stated above, the division finds that the requestor has failed to support that additional payment is due. Consequently, the requestor is not entitled to additional reimbursement for the services in dispute.

Conclusion

In resolving disputes regarding the amount of payment due for health care, the role of the Division is to adjudicate the payment, given the relevant statutory provisions and Division rules. The Division would like to emphasize that the outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent. Even though all the evidence was not discussed, it was considered.

The applicable rule for determining reimbursement of the disputed out-of-state outpatient hospital facility services is 28 Texas Administrative Code §134.1 regarding a fair and reasonable reimbursement. The information presented by the requestor was not persuasive. The division therefore concludes that the requestor has failed to establish by a preponderance of the evidence that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 14, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.